1 SUPERIOR COURT OF THE STATE OF CALIFORNIA
2 FOR THE COUNTY OF LOS ANGELES
3
4
5 RICHARD BOEKEN,)
)
6 Plaintiff,)
)
7 -vs-) NO. BC226593
)
8 PHILIP MORRIS, INCORPORATED, a)
corporation; INTERNATIONAL HOUSE)
9 OF PANCAKES, INCORPORATED, a)
corporation; DOES 1-100,)
10 inclusive,)
)
11 Defendants.)
)
12
13
14
15 DEPOSITION OF THOMPSON ADAMS, M.D.,
16 taken on behalf of the Plaintiff, at
17 11755 Wilshire Boulevard, Suite 1170,
18 Los Angeles, California, commencing at
19 10:00 A.M., on Thursday, March 15, 2001,
20 before FRANCES M. GARRITY, CSR NO. 8934 in
21 and for the State of California.
22
23
24
25

1 APPEARANCES
2
3
4 For the Plaintiff:
5 LAW OFFICES OF MICHAEL J. PIUZE
By: Michael J. Piuze, Esq.
6 117dd Wilshire Boulevard
Suite 1170
7 Los Angeles, California 90049
323-655-5353
8
9 For the Defendants:
10 ARNOLD & PORTER
By: Angel Tang, Esq.
11 777 South Figueroa Street
Suite 4400
12 Los Angeles, California 90017
213-243-4101
13
14 Also present:
15 Chris Johnson
16
17
18
19
20
21
22
23

1 LOS ANGELES, CALIFORNIA; THURSDAY, MARCH 15, 2001
2 10:00 A.M.
3
4 THOMPSON ADAMS, M.D.,
5 called as a witness on behalf of Plaintiff, having been
6 first duly sworn, was examined and testified as follows:
7
8 EXAMINATION
9 BY MR. PIUZE:
10 Q Tell me your name.
11 A Thompson Adams.
12 Q Do you have a C.V.?
13 A Yes.
14 Q Can I have it?
15 A Yes, you may.
16 MR. PIUZE: We'll mark this Exhibit 1.
17 (Plaintiff's Exhibit 1 was marked for
18 identification by the Certified Shorthand
19 Reporter and is attached hereto.)
20 BY MR. PIUZE:
21 Q Up to date?
22 A Yes.

23 Q When were you hired?
24 A I was contacted in October or --
25 MS. TANG: Objection. Vague and ambiguous.
5
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1 MR. PIUZE: You think so?
2 MS. TANG: Yes.
3 MR. PIUZE: I don't.
4 Q October?
5 A October or November of last year.
6 Q By whom?
7 A By Chris Johnson.
8 Q Who is Chris Johnson?
9 (Witness indicating.)
10 BY MR. PIUZE:
11 Q It's like a court drama.
12 Is that the guy who did it (indicating)?
13 A Yeah.
14 Q The man in the room with us?
15 A Yes.
16 Q How did you get in contact with Chris Johnson?
17 A He visited me with a representative from
18 Bonne, Bridges.
19 Q Let me guess. Mitzie?
20 A Yes.
21 Q How do you know Mitzie?
22 A I don't know Mitzie.
23 Q How did Mitzie contact you?
24 A I don't know. I did medical/legal work for
25 Bonne, Bridges, but other than that I don't have any
6
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1 idea.
2 Q I'm scheduled to be in trial with Bonne,
3 Bridges starting tomorrow on a medical/legal case. Lucky
4 me.
5 George Peterson, do you know him?
6 A I don't know if I worked with him. The name
7 sounds familiar.
8 Q I think he's the fifth guy.
9 Anyways, how many times do you think you've
10 done medical/legal work for Bonne, Bridges over the
11 years?
12 A Probably about eight.
13 Q With Mitzie?
14 A None.
15 Q I don't know her last name. It's
16 disrespectful, I guess. What is her last name?
17 A I believe, and my memory isn't as good, but I
18 think it's Dobson.
19 Q Dobson?
20 A Um-hmm.
21 Q Who have you worked with?
22 A Tom Scully, Rick Ryan, when he was there. A
23 fellow by the name of Marshall, I believe.
24 Q Okay. So how did Mitzie -- excuse me. How did
25 Ms. Dobson initiate the conversation?
7
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1 A Well, she just basically asked if I would be
2 willing to talk to people from Shook, Hardy & Bacon.
3 Q Did you know who Shook, Hardy & Bacon were?
4 A They told me they were lawyers in a tobacco

5 company.
6 Q Did she tell you which tobacco company?
7 A No.
8 Q Did she tell you the purpose of the review?
9 A Well, there wasn't a specific review. It was
10 just an introduction meeting.
11 Q The purpose of the meeting, did she tell you
12 that?
13 A She didn't specify a specific purpose of the
14 meeting.
15 Q Could you guess?
16 A No.
17 Q It had to do with tobacco and cancer?
18 A Frankly, you know, I wouldn't have been able to
19 anticipate, but when you realize they represent a tobacco
20 company, yeah. I mean, there was -- it would be
21 relationship between tobacco and cancer, yes.
22 Q You're an oncologist and treat cancer, and they
23 defend tobacco companies?
24 A I'm an oncologist that's willing to render
25 medical opinions about clinical situations.

1 Q Well, I wasn't wrong when I said you're an
2 oncologist that treats cancer?
3 A No. That's true, correct.
4 Q That's what you do most of your professional
5 time?
6 A Yes.
7 Q What percentage of the time is for treatment of
8 cancer, and then to rendering professional opinions?
9 A About 5 percent.
10 Q The medical/legal work in the past, are we
11 talking med-mal cases?
12 A Yes.
13 Q Also for the defendant?
14 A No. 25 percent for plaintiff.
15 Q Who has retained you for plaintiffs?
16 A There was Schumer, Schumer & Drane in
17 Santa Barbara would send cases, and if they thought there
18 was cause of action. There's a fellow in Northern
19 California near Sacramento, California. I had one case
20 with him. A situation that was unfortunate. I mean, the
21 clinical situation was unfortunate.
22 And let me think. I don't know how to get to
23 the 25 percent with the names that I mentioned, but
24 that's about what I remember it being. I can't think of
25 anyone else particularly right now that I've worked with

1 as a plaintiff.
2 Q How many medical/legal cases have you done?
3 A I guess not more than about 35, 30, something
4 like that.
5 Q Okay. All right. So when was your meeting
6 with Chris and Ms. Dobson?
7 A That was in, I think, August or so.
8 Q Where?
9 A In my office.
10 Q You mean, you let them on the same block with
11 me?
12 A I didn't know you were here then.
13 Q What did they have to tell you?

A They asked me questions about my opinions about lung cancer, and they asked me opinions about what I do, in terms of my practice. Very general questions.
Q Well, you never heard of Richard Boeken at that point?
A No.
Q What were your opinions about lung cancer? It's a pretty big question, it sounds like.
A Well, your question is also broad. I mean, there are several different kinds of -- pathological kinds of lung cancer.
Q Let me stop you. It is broad because it's

their question.
In other words, they asked you what you thought about lung cancer. What did you tell them?
A First of all, I don't recollect the specific -- what I was trying to convey to you in my answer was, it was a general discussion. Beyond that, I mean, I don't remember the specifics. I don't -- we didn't get into specifics.
Q Well, what was the general discussion?
A I think the general discussion centered around what kind of patients I saw in my practice; a little bit about what I thought about lung cancer and how it was treated.
I don't remember them specifically asking me questions at that time about what I thought the cause of lung cancer was at that time. I just don't remember. But I think they -- as near as I can tell, it was really, I think -- well, I had no idea of exactly what the long distance thought was that they were -- that they were going to utilize me for. But since I know Bonne, Bridges and respect them, and since they suggested that I consider meeting with them, I thought, "All right. I will meet with them."
Q You gave me three questions that were posed to you that day.

Can you give me the short answers to each?
A The questions being?
Q The three questions you told the court reporter, which she can reread to you to refresh your recollection, if you'd like.
A Yeah, please.
(Whereupon, the record was read as follows:
"A I think the general discussion centered around what kind of patients I saw in my practice; a little bit about what I thought about lung cancer, and how it was treated.")
THE WITNESS: Well, my patient practice consists of 75 percent medical oncologist and 25 percent hematology. In the medical oncology range, I deal with all treatment and diagnosis and staging of almost all cancers, all solid tumors.
And with regard to hematology, that constitutes hematologic malignancy and other disorders of the blood, such as coagulation, hemostasis, thrombotic problems, disorders of red and white cell function. So that's basically what my practice consists of.
BY MR. PIUZE:

23 Q Okay. Question Number 2.
24 A Number 2, having to do with lung cancer,
25 basically types of patients that I see, I see about, in
12

1 my own practice, about maybe 25 lung cancers a year that
2 are new.
3 And I see, in presentations, probably an
4 additional 50 or 75 patients, or 25 to 50 additional
5 patients that have lung cancer that are discussed in the
6 meetings that are held both at the City of Hope through
7 teleconferences equipment, and at John Wayne, where there
8 is a weekly conference in oncology.
9 Q So those people would not be your patients?
10 A Those would not be mine.
11 Q What is your role in the conference?
12 A Well, I participate in rendering opinions as to
13 diagnosis, treatment.
14 Q And other doctors similarly would be
15 participating when your patient's turn came up to be
16 discussed?
17 A Yes.
18 Q Okay. Thanks.
19 Is that your end of the answer to Question 2?
20 A I think so.
21 Q Okay. Question 3.
22 A I only remember two questions that were read
23 back.
24 Could I maybe have her reask the question?
25 Q Sure.
13

1 (Whereupon, the record was read as follows:
2 "A I think the general discussion centered
3 around what kind of patients I saw in my practice;
4 a little bit about what I thought about lung cancer,
5 and how it was treated.")
6 THE WITNESS: The answer to the way in which lung
7 cancer is treated is a really broad question, because it
8 depends on self-type.
9 BY MR. PIUZE:
10 Q Let me interpret that. I thought when the
11 court reporter was nice enough to read back for the
12 second time your answer, or what you had said was, "what
13 I thought about lung cancer." So only you know what you
14 meant by that. But I'm reminding you of what your words
15 were, "what I thought about lung cancer."
16 A Well, when I say, "what I thought about lung
17 cancer," I was talking about what my knowledge about lung
18 cancer was, based on my clinical experience.
19 Q Okay. So we're on the same wavelength.
20 What did you tell them?
21 A I said that it's a disease that more often than
22 not is legal, exception being early staged disease. Even
23 then, depending on what the pathological staging is, it
24 can be fatal. I don't know if at that time I talked
25 about anything about survival, depending on stage. The
14

1 management of the disease is basically dependent on the
2 cell type, whether it's a small cell or nonsmall cell in
3 nature. And it's also dependent on staging. So that
4 pretty much is what I can remember saying, in answer to

your question.
Q How often is lung cancer fatal?
A Well, more often than no.
Q Well, all right. Thank you. 51? 65?
A We have to define the stage. Because stage 3-B cancer probably is more around 7 percent five-year survival.
Q All stages, all lung cancers. Can you do that, or is it impossible?
A As I indicated, it's less than 50 percent if you put it altogether, because more often than not you have advanced stage of the disease.
Q All right. Can you do better than more than 50 percent fatal? Can you? That's a big number. It covers a lot of territory.
A I mean, I would say probably maybe mortality rate is in the range of around 60 percent for all cancers. 60 to 35. 50 to 60 percent.
Q Do you know who the John Wayne Cancer Institute was named after?
A Yes.

Q Who?
A John Wayne.
Q Why?
A He died of lung cancer.
Q He had a pulmoectomy, didn't he?
A Yes.
Q After his original diagnosis he lived a pretty good long time, didn't he?
A Yes. As a matter of fact, he actually died of gastric cancer.
MR. PIUZE: We are now off the record.
(Discussion held off the record.)
BY MR. PIUZE:
Q John Wayne did not die of lung cancer?
A It was gastric cancer, I believe.
Q And --
A But he did have lung cancer. I believe he had a lungectomy.
Q He survived for 15 years after he had that lung removed, didn't he?
A Yes.
Q Okay. So you had this meeting. How long did it last?
A About an hour.
Q And now what was your next involvement with

Mr. Boeken's case?
A I think the next involvement was in November when I was asked to review records on Mr. Boeken.
Q By?
A By Chris Johnson.
Q Did you ever write a Declaration in regards to Mr. Boeken?
A Yes.
Q When was that?
A It was in November.
Q And in the Declaration you thought he had no more than six months to live?
A Yes.

14 Q How long ago was that?
15 A That was in November.
16 Q How many months ago?
17 A It's about five, four -- well, it's not quite
18 April, so we've got December, January, February, March.
19 About four months.
20 Q Do you still think he's going to make it passed
21 the next couple of months?
22 A I think he will live two months, although he
23 has brain metastasis now, which he didn't have at that
24 time.
25 Q When you rendered the opinion you were unaware

1 with regard to the brain metastasis?
2 A That's right.
3 Q What is your best estimate now?
4 A Well, I think it's probably unlikely he would
5 live more than six months. Looking at the -- it depends
6 on how he responds to the radiation that he had.
7 But I would say if -- it would appear that his
8 survival will be dictated, right now, by the clinical
9 features of his brain metastasis. So if he responds
10 well, he could live between six months and a year.
11 But if he doesn't do well, then it will be a
12 little more closer to six months.
13 Q So the upside is maybe a year, max?
14 A That would be my best estimate, at this point,
15 based on what I see in the VNA.
16 Q If you had known of the brain metastasis at the
17 time that you wrote the Declaration, you would have
18 written the Declaration differently?
19 A Yeah, absolutely.
20 Q What would you have said?
21 A I wouldn't have said six months. I would have
22 considered the trial go forward in the normal fashion.
23 Q Well, the records came to you in November. And
24 before the records came to you in November, you heard
25 from -- tell me again whom. Chris?

1 A Yes.
2 Q What did Chris say at that time?
3 A Just that he was sending these records and
4 wanted me to review them. He mentioned there was a
5 question about what I thought the life expectancy was of
6 the patient.
7 Q And that's when the Declaration came up, at
8 this time?
9 A Yes.
10 Q You were charging 250 bucks an hour?
11 A Yes.
12 Q I'd like to inform you I had a deposition
13 within the last eight months of a truck driver expert and
14 he was charging me 260 bucks per hour for his opinion.
15 You may wanted to think about raising your rates a little
16 bit.
17 A That's encouraging to hear, but I set the rates
18 at what I thought they were worth.
19 Q You've been dealing with HMOs, have you?
20 A Not a lot. I've had some dealings with HMOs,
21 both from an administrative point of view and provider
22 point of view. But that's not the reason I charge what I

23 charge.
24 Q How long did you spend reviewing the records?
25 A The records? I think probably --
19
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1 MS. TANG: I'm sorry, in reference to the initial
2 meeting for the Section 36 Declaration?
3 MR. PIUZE: He said on the record it was November.
4 THE WITNESS: I think I spent about two, two and a
5 half hours reviewing them.
6 BY MR. PIUZE:
7 Q Do you know Dr. Sarna?
8 A Yes.
9 Q How?
10 A He and I trained together at UCLA a long time
11 ago.
12 Q Do you see him socially?
13 A No.
14 Q Professionally?
15 A No.
16 Q Are you aware his deposition was taken
17 yesterday?
18 A No.
19 Q Do you have any idea what his current thoughts
20 are regarding Mr. Boeken's condition?
21 A Well, I don't have any firsthand knowledge, but
22 I would imagine that our notes would be similar.
23 Q I guess we'll find out. The only one in the
24 room here who knows are these people (indicating),
25 because they were present at Dr. Sarna's deposition
20
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1 yesterday?
2 MS. TANG: I was the only one present there.
3 MR. PIUZE: I thought cigarette lawyers traveled in
4 packs.
5 MS. TANG: I was the only person there.
6 MR. PIUZE: I thought that up last time when I was
7 here.
8 MS. TANG: I think you've used that line a lot of
9 times.
10 MR. PIUZE: No. It's my first case. I'm a virgin.
11 You're my first.
12 Q So Dr. Sarna's treatment was appropriate
13 obviously?
14 A Yes.
15 Q Do you have any comments about stuff you think
16 you would have done different, that he should have done
17 different?
18 A No.
19 Q Was the surgery appropriate in your view?
20 A Yes.
21 Q Do you have any comments about the way the
22 surgery could have or should have been done differently?
23 A No.
24 Q Has the radiation been appropriate in your
25 view?
21
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1 A Yes.
2 Q Do you have any comments about the way that
3 could have been done or should have been done
4 differently?

5 A No.
6 Q Okay. Mr. Boeken has been getting quality
7 care, then?
8 A Yes.
9 Q And despite quality care, nature will have its
10 way with him?
11 A Yes.
12 Q What side effects, if any, as far as mental
13 acuity do the treatments that he has been receiving have
14 on a person?
15 A Well, chemotherapy has been shown to have some
16 cognitive dysfunctional-type problems, in terms of
17 memory, some specific kinds of intellectual skills could
18 be diminished by chemotherapy.
19 Q Such as?
20 A I don't remember exactly which ones, whether
21 it's counting. As I said, I believe some of them have to
22 do with memory. It may be with some mathematical
23 calculations. They're very subtle.
24 To my knowledge they only recently, within the
25 last couple of years, have been described. Particularly
22

1 in women taking breast cancer treatment.
2 Q How do steroids play into the treatment?
3 A Okay. Well, steroids are used to, in this
4 case, I suspect to decrease a chemical in the brain which
5 occurs from the brain metastasis. Then there is a
6 radiation therapy to the brain, which usually doesn't
7 cause acute changes in mental function, but beyond 12
8 months, and certainly by two years of brain radiation can
9 cause significant changes in mental function.
10 The steroids can cause some individuals to
11 behave in a manic way, so they can affect behavior
12 somewhat. But that would be my answer to your question.
13 Q Let's have your definition of manic as you used
14 it here, please.
15 A Manic means they're a little agitated. They
16 have a little bit of a fright of ideas, trouble sleeping,
17 that kind of symptomatology.
18 Q If I were to say that sometimes Mr. Boeken
19 seems a little thick, that his mental acuity seems a
20 little thick, without any further explanation, that sound
21 right to you, wrong to you, or neither?
22 A It would be hard for me to evaluate that
23 without having seen him before the treatment. Some
24 people are that way. But I understand he was a
25 stockbroker. That's what the information I had --
23

1 Q That's not really true.
2 A It's not true?
3 Q No.
4 A Regardless, I think that the answer is that one
5 should be able -- and I'm sure Dr. Sarna would be able to
6 do this -- document some specific changes that he
7 observed with treatment, based on the changes and the
8 functions that we talked about.
9 Q Would you do that?
10 A Would I do it in an individual?
11 Q Yeah, in the normal course of --
12 A I would make observations. I don't always
13 record all of them. If they're not going to have

14 clinical ramifications, I might not. But if asked
15 retrospectively, and if I could remember, I would comment
16 on them if I saw them.
17 Q Okay. For whatever it's worth, I'll disclose
18 to you that I think Mr. Boeken might be more accurately
19 called a security salesperson. And I could also disclose
20 to you that according to a psychiatrist or psychologist
21 having seen him in regard to the litigation and treatment
22 of litigation, it seems that he's of above-average
23 intelligence, if that's what you were trying to factor in
24 there.
25 A I will factor that in. With whatever good or

1 bad, that would be a factor.
2 Q What if I said something like he seems to have
3 tunnel vision sometimes, like just staring straight ahead
4 of him, as opposed to seeing more of the world around
5 him.
6 Would that sound right, wrong or neither to
7 you?
8 A In terms of what? In terms of treatment? In
9 terms of --
10 In other words, in terms of disease, I can't
11 answer --
12 Q In terms of life.
13 A Well, are you describing somebody what is
14 clinically depressed.
15 Q Might be. I don't know. I'm not --
16 A See the steroids do that. They cause just the
17 reverse of what you're describing. I mean, again, I'm
18 not actually sure what you're describing. I heard the
19 words, but I don't really know what the clinical feeling
20 for it is.
21 In other words, is he having problems relating
22 to people, does he have a negative view of the world? Is
23 that what you mean by this? Or are you saying that he
24 has visual acuity to the side, like a peripheral nervous
25 system? I don't think you mean that.

1 Q No, I don't.
2 Go ahead. Continue.
3 A What you're describing, if it is not organic,
4 would be more along the signs of someone who is
5 depressed.
6 Q If I said -- you know, and I apologize for the
7 general-type terms, but my total days in medication
8 school are zero.
9 That he seems to be focusing his energy or
10 attention on survival to the exclusion of -- everything
11 else is peripheral to survival, more peripheral. Does
12 that sound like something you see in cancer patients that
13 you're treating?
14 A It's one of the things I see, yes.
15 A cancer patient's reaction to their disease is
16 quite varied. Often it depends on what they really
17 believe their outlook to be, and what their understanding
18 of the disease is.
19 Many cancer patients don't really understand
20 how difficult their disease is. They want to believe
21 that it's better than and it is. They adjust
22 psychologically with less obvious depression. But if

23 they feel they understand that they have a fatal disease,
24 then they may be focusing all their attention on what the
25 significance of that is to them in their lives.
26

1 Q What are the most recent records that you
2 reviewed? What dates?
3 A I've seen records -- let's see.
4 I've seen records, I believe, the beginning of
5 this year. I'd have to actually go through -- I just --
6 I don't remember the exact last set of records, whether
7 it was from very late last year or early this year.
8 Q Let's put it this way to try to move on. The
9 latest records you've seen are at least a couple of
10 months old. Does that sound right?
11 A Yeah. They involve the brain metastasis.
12 Q Good enough.
13 Did you see any reference in the records that
14 you've reviewed to Mr. Boeken's mental acuity, mental
15 status, including depression?
16 A I have not -- I'm not aware of that
17 information. I just am not aware of it. It may be in
18 the record, but I'm not aware of it.
19 Q You've already explained that you believe all
20 the treatment is appropriate and constituted good quality
21 care. Let's look at that from the other side.
22 Has Mr. Boeken done everything he could to stay
23 alive, as you can --
24 MS. TANG: Objection. Calls for speculation.
25 THE WITNESS: From the time he was diagnosed?
27

1 BY MR. PIUZE:
2 Q Yes.
3 A Yes.
4 Q Diagnosed with what? Are you talking about
5 lung cancer?
6 A Yes.
7 Q What else have you read besides medical
8 records, if anything?
9 A I've reviewed, I've not read any depositions or
10 any other specifics with regard to the case, but I did
11 read an extensive amount of literature with regard to
12 lung cancer.
13 And I've also read the basic literature from
14 the surgeon general, and I've basically reviewed -- the
15 bulk of the information that I specifically read was in
16 this area.
17 And, in addition, I specifically reviewed two
18 books -- three books having to do with lung cancer, that
19 are fairly current.
20 Q What are the books?
21 A I made copies for you.
22 Basically one is Second Edition of Lung Cancer
23 by these authors.
24 MR. PIUZE: Let's have that marked as
25 Exhibit Number 2.
28

1 (Plaintiff's Exhibit 2 was marked for
2 identification by the Certified Shorthand
3 Reporter and is attached hereto.)
4 BY MR. PIUZE:

Q Lead author Harvey Pass, P-a-s-s.
A And this is a second reference (indicating).
MR. PIUZE: This is Exhibit 3. Lung Cancer, Second Edition, lead author is Roth, and the other is Exhibit 4.
(Plaintiff's Exhibits 3 and 4 were marked for identification by the Certified Shorthand Reporter and are attached hereto.)
THE WITNESS: And this is a third book (indicating).
MR. PIUZE: Exhibit 4. Tumors and Tumor-like Lesions of the Lung. Lead author Carter.
Q When did Chris tell you you should read these things?
A He didn't tell me. I'm the one that decided to read them.
Q Were you given a reading list and asked to choose from what was on the list?
A I had no reading list. My approach to this was to try and learn as much as I could about it, beyond what I do in my clinical practice, and specifically try to understand relationship as to causes of lung cancer, various types of lung cancer, areas that I might not --

you see, in the clinical practice we basically are concerned with small cell and nonsmall cell tumors.
Q Let's stop you right there. Remember where you were. I apologize for interrupting. We can have the court reporter read it back.
Why?
A Why?
Q Yeah.
A Because I wanted to understand what is presently available as to the information on causes of lung cancer, the changes in lung cancer that have occurred over time. Since tobacco is clearly a cause of lung cancer, I wanted to understand what was available as to the smoking habits and, uh, this is not something that I reviewed in my routine practice.
Q That was an appropriate answer to a bad question.
Why in the real world of treating lung cancer are you concerned only with the small cell versus nonsmall cell category?
A Well, that's because small cell lung cancer is treated and behaves clinically different than the nonsmall cell lung cancers.
Q In your clinical practice you never run into a question of what caused this cancer, true?

A Yeah. It basically -- you do run into the question. Patients do want to know, but in a practical way the management and significance to the patient that you're seeing is -- doesn't involve having to know the cause. What you have to do is know the management and the behavior. So in a practical sense, clinical treating oncologists are less likely to be involved with understanding the causes.
Now, that isn't -- I don't want it to be an oversimplification because we do educate the community and other physicians if we know causes that exist. And so in that sense it's part of a clinical oncologist's -- it's his role to try to understand as much as he can

about the disease, but the practical situation is that
lung cancer, which is unfortunately very common, is a
disease where we don't worry as much about the etiology
in the individual type of patient, but are more concerned
with what the cell type is and what the stage is.
Q "We" being treating oncologists?
A Yes.
Q Now, what percentage of your practice now
involves lung cancer?
A Well, it is still the most common tumor,
although my individual practice probably has more breast
cancer than lung cancer in it.
31
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But of the 75 percent of medical oncology, I
suspect probably 20 percent is due to lung cancer.
Q 20 percent of the 75 percent?
A Yes.
Q How many lung cancer patients do you have right
now?
A Probably about 20.
Q Lung cancer patients?
A Yes.
Q Is the 20 percent of your oncology practice,
which you've told me equals lung cancer patients, is that
a figure that is accurate going back 10 years?
A Yes.
Q 20 years?
A Well, I don't remember the exacts, but, in
other words, lung cancer is one of the more frequent
tumors. So, you see, I would say it's generally been my
experience, yes.
Q Does lung cancer, based on your knowledge --
I'm looking for your personal knowledge now as opposed to
what you've reviewed for this case -- does it follow any
kind of socioeconomic trail?
A In my personal knowledge, I wouldn't be able to
answer that question as saying that I've identified a
specific trail.
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Q Now, you practice now in the Brentwood area,
correct?
A West L.A.
Q Upper middle class socioeconomics?
A Yes.
Q Have you practiced in different geographic
locations in the past that would yield different
demographics, as far as income?
A No.
Q So all you can compare is yourself to yourself
then, or this area to this area?
A Yes.
Q So let's go beyond what you do in your personal
day-to-day practice. What about what you know from
attending meetings and talking to colleagues? Is lung
cancer following a socioeconomic trend?
A It tends to be related -- well, I'm trying to
figure out if this has ever been really discussed in
meetings. I'm not aware. I'm just not aware that I've
heard that kind of information discussed in meetings,
specifically, the socioeconomic factors in lung cancer.
So I can't really comment on that or say that I've heard

23 that in my discussions.
24 Q What's in the box?
25 A The box has, and I've summarized, I think, the
33
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1 records here, but these are surgeon general reports.
2 There are articles that have to do with lung cancer
3 histologic types, clinical behavior, that kind of thing.
4 And they're summarized here (indicating).
5 Q When you say "they're summarized," you're
6 talking about the titles or contents?
7 A Titles.
8 Q Have you read all the reports in that box?
9 A I actually have. I mean -- I have read -- I
10 mean, I certainly don't remember everything and every
11 individual article, but I have looked at and reviewed
12 everything that's in that box.
13 Q How long did that take?
14 A It took about, I don't know, 25 hours, 30
15 hours.
16 Q Is that my copy?
17 A Yes.
18 Q Thank you. I will accept. I'm not going to
19 have those documents marked because of my love for trees,
20 but I'd like to have your handwritten title summary
21 marked as Exhibit Number 5, please.
22 (Plaintiff's Exhibit 5 was marked for
23 identification by the Certified Shorthand
24 Reporter and is attached hereto.)
25 THE WITNESS: These were the records that have been
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1 reviewed (indicating).
2 BY MR. PIUZE:
3 Q Just leave that aside for a minute.
4 How many pages is Exhibit Number 5?
5 A There are four.
6 Q Thank you. Here's Exhibit 5. Four pages,
7 handwritten.
8 This Exhibit 4. "Tumor and Tumor like Lesions
9 of the Lung, Volume 36 in the Series. Major Problems In
10 Pathology."
11 What did you read in that book?
12 A I was just looking, basically, at what -- what
13 they described as different types of adenocarcinomas.
14 Q They who?
15 A The authors.
16 Q Are the authors pathologists?
17 A Yes.
18 Q How come you're in a pathology book?
19 A Because I think it's -- in order to understand
20 what the current pathology link -- in order to understand
21 clinical pathological correlations we have to be on the
22 same page as to what the terms mean.
23 Q You rely on pathologists in your business all
24 the time, don't you?
25 A Absolutely.
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1 Q Are there occasions when you ever, after
2 getting a pathology report go look at the slides yourself
3 to look at the pathologies?
4 A Yes.

5 Q What kind of situation?
6 A Well, in order to double check is probably --
7 it would be primarily occurring in hematologic problems
8 where the variations sometimes are a little more
9 subjective. Or it will be simply a matter of sitting
10 down and talking with the pathologist and sharing the
11 clinical findings of the case. There are situations
12 that -- where that's helpful. It particularly comes up
13 in types of tumors where there's no nonprimary and you're
14 trying to figure out where the origin of the tumor was.
15 Q Let's come out of hematology now and go for the
16 remaining 75 percent of your practice.
17 Are there occasions when after receiving a
18 pathology report you decide that you want to take a look
19 at the specimen yourself under a microscope?
20 A Well, I mentioned where you don't know where
21 the primary tumor is. That's certainly one thing where I
22 always go down and look at the slides with the
23 pathologist.
24 Q Is that the extent of it?
25 A Well, there may be others. I just -- where I
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1 routinely do it, I would say that would be the one thing
2 that I can think of where I routinely do it.
3 When I was in practice originally, back in the
4 beginning, I did it more often because there was less
5 strength in pathology at the time. But pathology has
6 gotten so strong, with markers, and there's a less
7 subjective aspect of pathology now, and there's less of a
8 need to review routine cases, in my opinion.
9 Q Why don't you give me a year that separates,
10 again, when you used to do it more frequently and your
11 current status in regard to how often you review path
12 slides?
13 A Well, in the '70s I think I routinely reviewed
14 most, but not all the path slides.
15 And through the'80s, I just did less and less.
16 And presently the area where -- and I should say that I'm
17 answering your question as you asked it, mainly looking
18 at pathology with the slides. But you just remember that
19 in the conferences that are attended, the pathology is
20 presented, so you see the pathology presented by the
21 pathologist. And in that sense I'm constantly exposed to
22 pathological material, but breast cancer is an area where
23 I would tend to review the slides more, more than I do
24 with most other types of tumors.
25 Q All right. That's nice. Thank you. I think
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1 you got off the track a little, though. It's not a
2 criticism, but let me put you back on.
3 Can you just sort of give a timeline when you
4 stopped reviewing path slides very frequently and the
5 present where you do it infrequently? And you got into
6 in the '80s, and then decreased a little bit?
7 A Well, I think the '80s and '90s were
8 approximately the same. I don't -- so the answer is that
9 I just right now -- I'm not reviewing the slides as much
10 as I was earlier, but one of the reasons may be because
11 there is better presentation of pathological material at
12 conferences, and in some cases -- in fact, frequently in
13 difficult clinical problems, they are both in tumor

14 conference where the slides on the individual patient are
15 showed.
16 Q Most of your patients who you treat, they don't
17 get presented at the conference, do they?
18 A Well, I mean, it means that City of Hope do,
19 but City of Hope conference doesn't involve looking at
20 pathology slides. But the patients get presented.
21 Q Let's leave that out. We're not talking about
22 the City of Hope, anymore. Your patients, do you ever
23 treat patients that aren't involved with the City of
24 Hope?
25 A Understand that the hospital that I use is
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1 St. John's, and the conferences we're talking about
2 are -- in other words, it is City of Hope. Patients in
3 west Los Angeles use St. John's Hospital. They don't go
4 somewhere else. So they may come to see me at the west
5 Los Angeles office, but they still are St. John's
6 patients, as much as they're City of Hope patients. And
7 they get presented at the St. John's tumor conference.
8 Q Are you there?
9 A Yes.
10 Q You said primarily?
11 A Well, there is a weekly breast cancer and every
12 two-week tumor conference.
13 Q What percentage of your patients get presented
14 at these conferences?
15 A Well, it depends on -- let's see. Percentage
16 of patients? Probably about -- probably 5 to 10 percent.
17 Q What percent of your nonbreast cancer patients
18 get presented at the City of Hope conference?
19 A I'd say about the same.
20 Q What percentage of your lung cancer patients
21 get presented at these conferences?
22 A Again, the cases -- there isn't a lung cancer
23 conference. It will be the same as all the others.
24 Q 5 to 10 percent?
25 A Yeah.
39
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1 Q And aside from those 5 to 10 percent of
2 patients that get presented at those conferences, the
3 only time that you get involved with path slides, now, in
4 the '90s, in the '80s, is when you're trying to figure
5 out where the primary tumor is?
6 Do I have that right?
7 MS. TANG: Objection. Misstates what his prior
8 testimony was.
9 THE WITNESS: I think it would be fair to say that
10 that's the most frequent time that I'm presently looking
11 at slides. That's the most common reason for me to look
12 at slides.
13 BY MR. PIUZE:
14 Q Okay. Another reason? So far I haven't heard
15 one. I mean --
16 A Well, there are reasons, but it depends on an
17 individual case. I've indicated that in cases of breast
18 cancer I will often look at them more, because of the
19 difficulty with trying to determine aspects of breast
20 cancer pathologically. But I can't honestly tell you a
21 specific reason right now why I would go to look at a
22 particular slide in some of the other diseases.

23 Q What pathology service do you use, pathology
24 company?
25 A The only pathology department I work with is

1 primarily St. John's. I do work with Santa Monica, UCLA,
2 as well.
3 Q Who is the boss over at St. John's pathology?
4 Do you know?
5 A Yeah. David Krazney.
6 Q What about UCLA?
7 A Used to be Dean Harvey. And UCLA is -- no,
8 over there I'm not sure who is in charge.
9 Q Over where?
10 A At Santa Monica.
11 Q When you mentioned UCLA, you were talking about
12 Santa Monica Hospital as opposed to the medical campus?
13 A Yes.
14 Q Have you talked to any physicians about this
15 litigation?
16 A No.
17 Q Aside from the lawyers with whom you've come
18 into contact, have you talked to anyone else about this
19 litigation?
20 A No.
21 Q What other lawyers besides Ms. Dobson, Chris
22 and Ms. Tang have you come into contact with in this
23 litigation?
24 A I'm not aware of any others. There may have
25 been one other woman, but I don't remember now her name.